

**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**PART I: GENERAL INFORMATION**

Requestor's Name and Address:	MFDR Tracking #:	M4-07-4328-01
HARRIS METHODIST FORT WORTH 3255 W PIONEER PKWY ARLINGTON TX 76013-4620		
Respondent Name and Box #:		
Tarrant County Box #: 43		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "I am filing this MDR to appeal for payment of xrays and CT scans at MARS rates and the emergency room charges at 75% of billed charges. CPT code 71101 allows \$39.00, insurance underpaid by \$5.60. CPT code 72193 allows \$369.00, insurance underpaid by \$29.51. CPT code 74160 allows \$376.00, insurance underpaid by \$36.51. The emergency room charges should be paid at 75% of billed charges for trauma treatments. Insurance underpaid by \$549.81. Total amount due is \$621.43."

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - \$621.43
3. Hospital Bill
4. EOBs
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: The respondent did not submit a position statement with the response.

Principle Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
4/19/2006	16, 241, 270, W1	Emergency Room Visit	\$621.43	\$0.00
Total Due:				\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
 - 16 – No explanation for reason code 16 was documented on the EOB as submitted, however the Division's *Direction on Use of the ANSI Claim Adjustment Reason Codes* published March 2006 describes this code as "Claim/service lacks information needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate."
 - 241 – "Not documented"
 - "The medical report was not submitted to support this service."

- 270 – “No allowance has been recommended for this procedure/service/supply please see special *note* below.”
 - “90760 is not a valid code”
 - W1 – No explanation for reason code W1 was documented on the EOB as submitted, however the Division’s *Direction on Use of the ANSI Claim Adjustment Reason Codes* published March 2006 describes this code as “Workers Compensation State Fee Schedule Adjustment.”
2. This dispute relates to an outpatient emergency room visit including laboratory and radiological services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that “reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers’ Compensation Act, §413.011”...
 3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
 4. Division rule at 28 TAC §134.401(a)(3), effective August 1, 1997, 22 TexReg 6264, states that “Services such as outpatient physical therapy, radiological studies and laboratory studies are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific services”...
 5. Division rule at 28 TAC §134.401(a)(5), effective August 1, 1997, 22 TexReg 6264, states that “Emergency services that do not lead to an inpatient admission are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific services”...
 6. Division rule at 28 TAC §133.307(c)(2)(A), effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires that the request shall include “a copy of all medical bill(s)”... “as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter”... This request for medical fee dispute resolution was received by the Division on March 15, 2007. Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of all medical bill(s) as originally submitted to the carrier. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed by the Division as required under 28 TAC §133.307(c)(2)(A).
 7. Division rule at 28 TAC §133.307(c)(2)(B), effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires that the request shall include “a copy of each explanation of benefits (EOB) relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB.” Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of the EOB detailing the insurance carrier’s response to the request for reconsideration. Nor has the requestor provided evidence of carrier receipt of the request for an EOB. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(B).
 8. Division rule at 28 TAC §133.307(c)(2)(F)(iii), effective December 31, 2006, 31 TexReg 10314, applicable to requests for medical fee dispute resolution filed on or after January 15, 2007, requires that the request shall include “a position statement of the disputed issue(s) that shall include”... “how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues”... This request for medical fee dispute resolution was received by the Division on March 15, 2007. Review of the requestor’s position statement finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(F)(iii).
 9. The requestor’s position statement asks for “payment of xrays and CT scans at MARS rates”; however, Division rule at 28 TAC §134.401(a)(3), effective August 1, 1997, 22 TexReg 6264, states that “Services such as outpatient physical therapy, radiological studies and laboratory studies are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific services”... Review of the documentation submitted by the requestor finds that the X-ray and CT services performed by the provider have no MAR and shall be reimbursed at a fair and reasonable rate.
 10. The requestor’s position statement further asks for payment of “the emergency room charges at 75% of billed charges.” Review of the submitted evidence finds that the requestor did not discuss or explain how it determined that payment of 75% of billed charges would result in a fair and reasonable rate of reimbursement, nor has the requestor provided documentation to support the proposed methodology. Furthermore, a reimbursement methodology based on a percentage of billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 *Texas Register* 6276 (July 4, 1997) that “A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than

for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.” Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment in the amount of 75% of the billed charges would be a fair and reasonable rate of reimbursement for the services in dispute. Therefore, reimbursement in the amount of 75% of the provider’s billed charges cannot be recommended.

11. Division Rule at 28 TAC §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to requests for medical fee dispute resolution filed on or after January 15, 2007, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable”... Review of the submitted documentation finds that the requestor has not provided evidence to support the requested reimbursement for the disputed services. Nor has the requestor discussed how payment of the amount sought would be consistent with the criteria of Labor Code §413.011, or would ensure similar reimbursement to similar procedures provided in similar circumstances. Review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that the payment amount sought is a fair and reasonable rate of reimbursement in accordance with 28 TAC §134.1. The request for additional reimbursement is not supported.
12. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(A), §133.307(c)(2)(B), §133.307(c)(2)(F)(iii) and §133.307(c)(2)(G). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.250, §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature

Medical Fee Dispute Resolution Officer

Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.